Washington State Employee Assistance Program (EAP)
Network of Contracted Provider Assessment

Complete this form after the initial visit and return by fax to EAP at 206-281-6319 within 5 working days following initial visit.

EAP Referral Number:

Presenting Problem: Provide a brief description of presenting issue and include duration, severity, pertinent history, and a brief mental status.

Precipitating Event: What happened to bring client in today, why now?

Risk Factor: Note type of risk and level of risk.

If risk is present, document the safety plan discussed with client.

Impact on Job Performance: Assess the impact of presenting issue on job and include performance, attendance and interpersonal relationships.

Treatment History: Indicate type of treatment, level of care, and dates of service.

Chemical Dependency	**Level of Care**	**Dates of Service**
Mental Health	**Level of Care**	**Dates of Service**

Current Treatment: Indicate type of treatment, level of care, and dates of service.

Chemical Dependency	**Level of Care**	**Dates of Service**

Mental Health	Level of Care	Dates of Service

Substance Use/Abuse (check substance of choice)

- ☐ Amphetamine
- ☐ Cocaine/Crack
- ☐ Marijuana
- ☐ Opiates
- ☐ Poly Substance
- ☐ Prescription Medication
- ☐ Steroids
- ☐ Other
- ☐ None

Addictions (check all that apply)

- ☐ Food/Eating
- ☐ Gambling
- ☐ Internet/Computer
- ☐ Religion
- ☐ Sex-Pornography
- ☐ Spending
- ☐ Other
- ☐ None

Health/Medical Concerns:

Medications: Include prescription(s) and OTC.

Social Support Network: Include self care activities.

Relevant Family History: Include mental health, substance abuse or risk issues, treatment, and medical concerns.

Provider Name (print): _____

Provider Signature: _____Credentials:_____ Date: _____